

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-015513

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 87

FILED MAY 7 1963

1. PLACE OF DEATH a. COUNTY Dunklin		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Dunklin	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kennett		Length of stay in 1b 25 days	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Dunklin Co. Mem. Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fannie Daily		4. DATE OF DEATH Month April Day 30 , Year 1963	
5. SEX Female	6. COLOR OR RACE Cau.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/12/1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11a. FATHER'S NAME Henry Clay Hart		11b. MOTHER'S MAIDEN NAME Sarah (
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, if unknown) (If yes, give war or dates of service) No		12b. SOCIAL SECURITY NO. 16	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis		14. NAME OF HUSBAND OR WIFE Calvin Daily (Dec.)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Senath	
21. I attended the deceased from 6:30 A.M. to 4-29-63 and last saw her alive on 4-29-63 Death occurred at 6:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.		22. ADDRESS Cardwell, Mo	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/2/1963	
23c. NAME OF CEMETERY OR CREMATORY Senath		23d. LOCATION (City, town, or county) Senath Missouri	
24. FUNERAL DIRECTOR McDaniel Funeral Service, Senath, Mo.		25. DATE RECD. BY LOCAL REG. 5-31-63	
26. REGISTRAR'S SIGNATURE Carl H. H. H.		27. REGISTRAR'S SIGNATURE Carl H. H. H.	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Tommy L. Roberts

Licensed Embalmer No.

4886

P. O. Address

Kennett, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.